

SEARCH REQUEST FORM
Scientific and Technical Information Center

Requester's Full Name: P. Laufer Examiner# : 73139 Date: 10/15/01
 Art Unit: 2100 Phone Number: 306-4160 Serial Number: 091821371
 Mail Box and Bldg/Room Location: _____ Results Format Preferred (circle): Paper Disk E-mail

If more than one search is submitted, please prioritize searches in order of need.

Please provide a detailed statement of the search topic, and describe as specifically as possible the subject matter to be searched. Include the elected species or structures, keywords, synonyms, acronyms, and registry numbers, and combine with the concept or utility of the invention. Define any terms that may have a special meaning. Give examples or relevant citations, authors, etc., if known. Please attach a copy of the cover sheet, pertinent claims, and abstract.

Title of Invention: _____

Inventors (please provide full names): _____

Earliest Priority Filing Date: _____

For Sequence Searches Only Please include all pertinent information (parent, child, divisional, or issued patent numbers) along with the appropriate serial number.

litigation

5,890,128

10-15-01 P12:08 IN

STAFF USE ONLY

Searcher: S Green
 Searcher Phone: 6-4767
 Searcher Location: 4B40
 Date Searcher Picked Up: 10/15/01
 Date Completed: 10/15/01
 Searcher Prep & Review Time: _____
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Type of search

NA Sequence (#) _____
 AA Sequence (#) _____
 Structure (#) _____
 Bibliographic _____
 Litigation _____
 Full Text _____
 Patent Family _____
 Other _____

Vendors and cost where applicable

STN 1 min
 Dialog 6 1/2 min
 Questel/Orbit 3 1/2
 Dr. Link _____
 Lexis/Nexis _____
 Sequence System _____
 WWW/Internet _____
 Other (specify) _____

Green, Shirelle

From: Laufer, Pinchus
Sent: Monday, October 15, 2001 11:41 AM
To: STIC-EIC2100
Subject: More litigation searches - CAN THESE BE PUT "NEXT"

Importance: High

Here are 2 more; CAN THESE BE DONE BEFORE THE 3?

- (1) 09/821,371 which is a Reissue of US Patent 5,890,128 Inventors: Benjamin Diaz and M. Inez Genera
- (2) 09/871,978 which is a Reissue of US Patent 5,910,181 Inventors: Makoto Hatakenaka et al.

Thank You,

Pinchus

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S1 1 PN="US 5890128"
?t s1/9

1/9/1

DIALOG(R)File 345:Inpadoc/Fam. & Legal Stat
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15093811

Basic Patent (No, Kind, Date): US 5890128 A 990330 <No. of Patents: 001>

PATENT FAMILY:

UNITED STATES OF AMERICA (US)

Patent (No, Kind, Date): US 5890128 A 990330

PERSONALIZED HAND HELD CALORIE COMPUTER (ECC) (English)

Patent Assignee: DIAZ H BENJAMIN (US); GENERA M INEZ (US)

Author (Inventor): DIAZ H BENJAMIN (US); GENERA M INEZ (US)

Priority (No, Kind, Date): US 610380 A 960304

Applic (No, Kind, Date): US 610380 A 960304

National Class: * 705002000: 128921000: 364400000: 364700000

IPC: * G06F-017/00

Derwent WPI Acc No: * G 99-243498: G 99-243498

Language of Document: English

UNITED STATES OF AMERICA (US)

Legal Status (No, Type, Date, Code, Text):

US 5890128 P 960304 US AE APPLICATION DATA (PATENT)

05 5000120 1 500504 05 AE AFFICAI
(APPL. DATA (PATENT))

US 610380 A 960304

US 5890128 P 990330 US A 610380 A 9603 P A T E N T

Litigations - 5890128 - P. Laufer

?us5890128/pn

Term not in index/PN-LITA : US5890128

LGST	1
CRXX	1
LITA	0
PAST	1

** SS 1 : Results 3

Search statement 2

?prt ss1 max 1-3

1/3 LGST (1/1) - (C) LEGSTAT
PN - US 5890128 [US5890128]
AP - US 610380/96 19960304 [1996US-0610380]
DT - US-P
ACT - 19960304 US/AE-A
APPLICATION DATA (PATENT)
{US 610380/96 19960304 [1996US-0610380]}
- 19990330 US/A
PATENT
- 20010814 US/RF
REISSUE APPLICATION FILED
20010329
UP - 2001-40

2/3 CRXX (1/1) - (C) CLAIMS/RRX
AN - 3131768
PN - 5,890,128 A 19990330 [US5890128]
PA - Diaz, H BenjaminGenera, M Inez
PT - E (Electrical)
ACT - 20010329 REISSUE REQUESTED
ISSUE DATE OF O.G.: 20010814
REISSUE REQUEST NUMBER: 09/821371
EXAMINATION GROUP RESPONSIBLE FOR REISSUEPROCESS: 2761

Reissue Patent Number:

UP - 2001-33
UACT- 2001-08-14

3/3 PAST (1/1) - (C) PAST
AN - 200133-001702
PN - 5890128 A [US5890128]
DT - A (UTILITY)
OG - 2001-08-14
CO - REA
ACT - REISSUE APPLICATION FILED
SH - REISSUE APPLICATION FILED

LEVEL 1 OF 1 PATENT

5,890,128

<=2> GET 1st DRAWING SHEET OF 17

Mar. 30, 1999

Personalized hand held calorie computer (ECC)

INVENTOR: Diaz, H. Benjamin, P. O. Box 294, Brea, California 92622
Genera, M. Inez, P. O. Box 294, Brea, California 92622

CORE TERMS: screen, user, button, caloric, menu, calories, lifestyle, fat, target, calorie...

LEXIS-NEXIS
Library: PATENT
File: ALL

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Your search request has found no CASES.

To edit the above request, use the arrow keys. Be sure to move the cursor to the end of the request before you enter it.

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For further explanation, press the H key (for HELP) and then the ENTER key.

LEXIS-NEXIS
Library: PATENT
File: CASES

5,890,128 OR 5890128

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LEXIS-NEXIS
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LEXIS-NEXIS
Library: PATENT
File: JNLS

}

57 results 87

Document ID	Issue Date	Inventor	Current OR	Current XRef	Pages
1 EP 537113 A119930412	IN			11	
2 US 5890128 A	19990330	Diaz, H. Benjamin , et al.	705/2	128/921 ; 700/90 ; 708/100	33
3 US 5796640 A	19980818	Sugarmen, Henry , et al.	708/132	128/921	23
4 US 5704350 A	19980106	Williams, III, William B.	600/300	128/921 ; 708/132	24
5 US 3984666 A	19761005	Barron, Benjamin	702/44	322/28 ; 377/19 ; 482/57 ; 482/8 ; 73/379.07	7

DIALOG 17 NOVEMBER 2001

File 2:INSPEC 1969-2001/Nov W3 (c) 2001 Institution of Electrical Engineers
File 6:NTIS 1964-2001/Dec W1 (c) 2001 NTIS, Intl Cpyrght All Rights Res
File 7:Social SciSearch(R) 1972-2001/Nov W3 (c) 2001 Inst for Sci Info
File 8:Ei Compendex(R) 1970-2001/Nov W2 (c) 2001 Engineering Info. Inc.
File 9:Business & Industry(R) Jul/1994-2001/Nov 16 (c) 2001 Resp. DB Svcs.
File 14:Mechanical Engineering Abs 1973-2001/Nov (c) 2001 Cambridge Sci Abs
File 15:ABI/Inform(R) 1971-2001/Nov 17 (c) 2001 ProQuest Info&Learning
File 16:Gale Group PROMT(R) 1990-2001/Nov 16 (c) 2001 The Gale Group
File 20:World Reporter 1997-2001/Nov 17 (c) 2001 The Dialog Corporation
File 34:SciSearch(R) Cited Ref Sci 1990-2001/Nov W3 (c) 2001 Inst for Sci Info
File 35:Dissertation Abs Online 1861-2001/Nov (c) 2001 ProQuest Info&Learning
File 42:Pharmaceutcl News Idx 1974-2001/Nov W2 (c) 2001 ProQuest Info&Learning
File 43:Health News Daily 1990-2001/Nov 16 (c) 2001 F-D-C reports Inc.
File 63:Transport Res(TRIS) 1970-2001/Oct (c) fmt only 2001 Dialog Corp.
File 65:Inside Conferences 1993-2001/Nov W2 (c) 2001 BLDSC all rts. reserv.
File 74:Int.Phrm.Abs. 1970-2001/Oct (c) 2001 Amer.Soc.of Health-System Pharm.
File 77:Conference Papers Index 1973-2001/Nov (c) 2001 Cambridge Sci Abs
File 80:TGG Aerospace/Def.Mkts(R) 1986-2001/Nov 16 (c) 2001 The Gale Group
File 94:JICST-EPlus 1985-2001/Oct W1 (c) 2001 Japan Science and Tech Corp(JST)
File 99:Wilson Appl. Sci & Tech Abs 1983-2001/Sep (c) 2001 The HW Wilson Co.
File 108:AEROSPACE DATABASE 1962-2001/OCT (c) 2001 AIAA
File 129:PHIND(Archival) 1980-2001/Nov W2 (c) 2001 PJB Publications, Ltd.
File 130:PHIND(Daily & Current) 2001/Nov 16 (c) 2001 PJB Publications, Ltd.
File 148:Gale Group Trade & Industry DB 1976-2001/Nov 16 (c) 2001 The Gale Group
File 149:TGG Health&Wellness DB(SM) 1976-2001/Nov W2 (c) 2001 The Gale Group
File 155:MEDLINE(R) 1966-2001/Dec W2
File 160:Gale Group PROMT(R) 1972-1989 (c) 1999 The Gale Group
File 169:Insurance Periodicals 1984-1999/Nov 15 (c) 1999 NILS Publishing Co.
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File 256:SoftBase:Reviews,Companies&Prods. 85-2001/Oct (c) 2001 Info.Sources Inc
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File 621:Gale Group New Prod.Annou.(R) 1985-2001/Nov 16 (c) 2001 The Gale Group
File 623:Business Week 1985-2001/Nov 16 (c) 2001 The McGraw-Hill Companies Inc
File 624:McGraw-Hill Publications 1985-2001/Nov 17 (c) 2001 McGraw-Hill Co. Inc
File 625:American Banker Publications 1981-2001/Nov 16 (c) 2001 American Banker
File 634:San Jose Mercury Jun 1985-2001/Nov 16 (c) 2001 San Jose Mercury News
File 635:Business Dateline(R) 1985-2001/Nov 17 (c) 2001 ProQuest Info&Learning
File 636:Gale Group Newsletter DB(TM) 1987-2001/Nov 16 (c) 2001 The Gale Group
File 637:Journal of Commerce 1986-2001/Nov 16 (c) 2001 Journal of Commerce Inc
File 810:Business Wire 1986-1999/Feb 28 (c) 1999 Business Wire
File 813:PR Newswire 1987-1999/Apr 30 (c) 1999 PR Newswire Association Inc

Set	Items	Description
S1	46268	NUTRITION??? (5N) (FAT?? OR CALOR???? OR SUGAR?? OR CHOLES-TEROL?? OR SODIUM OR PROTEIN?? OR SALT OR CARB?? OR CARBOHYDRATE???)
S2	45969	(EXERCIS???? OR RUN OR RUNNING OR WALK OR WALKING OR JOG???? OR LIFT????) (5N) (FAT?? OR CALOR???? OR SUGAR?? OR CHOLESTEROL?? OR SODIUM OR PROTEIN?? OR SALT OR CARB?? OR CARBOHYDRATE???)
S3	524	S1 (S) S2
S4	736	S1 (10N) (TIME OR PERIOD OR INTERVAL)
S5	16659	NUTRITION??? (10N) (TIME OR PERIOD OR INTERVAL)
S6	1826	S2 (10N) (TIME OR PERIOD OR INTERVAL)
S7	23	(S4 OR S5) AND S6
S8	24	S3 AND (S4 OR S5)
S9	20	S3 AND S6
S10	55	S7 OR S8 OR S9
S11	48	RD S10 (unique items) [Scanned ti,kwic all]

11/9/12 (Item 1 from file: 149)

DIALOG(R)File 149:TGG Health&Wellness DB(SM) (c) 2001 The Gale Group. All rts. reserv.

02010682 SUPPLIER NUMBER: 76966168 (THIS IS THE FULL TEXT)

NUTRITION AND EXERCISE.

GOLDBERG, JOCELYN M.

RN, 64, 7, 34

July, 2001

PUBLICATION FORMAT: Magazine/Journal; Refereed

ISSN: 0033-7021

LANGUAGE: English

RECORD TYPE: Fulltext

TARGET AUDIENCE: Professional

WORD COUNT: 3298

LINE COUNT: 00276

1 TEXT: Nutrition and exercise aren't merely adjuncts to treating diabetes, they're essential
2 components of the prescription for effective care. Understanding what they entail will help you
3 support your patients and work effectively with other members of the diabetes team.

4 Nutrition and exercise are essential to maintaining the health and quality of life of people
5 with diabetes mellitus. In light of this fact, patients with diabetes have a lot to learn: how to
6 monitor their blood glucose levels, what changes to make in their eating habits, and how to sustain
7 prescribed levels of physical activity. In addition, many will have to learn how to comply with
8 a regimen of oral antidiabetic agents, insulin, or both.

9 Acquiring these skills can be a monumental task, one that patients should not be expected
10 to accomplish alone. That's why managing diabetes requires ongoing intervention and education
11 by a concerned multidisciplinary team, which should include--at a minimum--the patient's
12 physician, a nurse, and a registered dietitian (RD). Because a nurse and a dietitian do much of the
13 patient teaching, they should have specialized training or certification in diabetes and education.
14 (1)

15 Whether you're an official member of the diabetes team or you

16 JOCELYN GOLDBERG is an advanced practice nutritionist at the Mount Sinai Diabetes
17 Center in New York City.

18 STAFF EDITOR. Emil Vernarec simply have patients with diabetes in your care, you need
19 to understand how nutrition and exercise affect blood glucose. With this knowledge, you will be
20 better able to support your patient's adherence to the nutrition, exercise, and self-management
21 plans developed by the team.

22 Diet is best seen as a "nutrition prescription"

23 For patients with either Type 1 or Type 2 diabetes, diet should be considered medical
24 nutrition therapy. According to the American Diabetes Association (ADA), there is no one
25 "diabetic" or "ADA" diet; instead, what's required is an individualized "nutrition prescription."

26 Individualizing medical nutrition therapy can be a complex task. That's why the ADA

27 recommends that it be done by an RD, who takes into account the patient assessment, outcomes,
28 and treatment goals. (2,3) The assessment is a detailed one. It needs to include the patient's
29 medical history, current medication use, frequency and results of blood glucose monitoring, lab
30 data, height and weight history, body composition results, typical eating patterns, timing of meals
31 and snacks, and exercise regimen.

32 It also must include patient lifestyle data, such as work schedule and frequency of dining
33 out or eating take-out food. The patient's learning style, readiness to change, and any barriers to
34 such change must also be taken into account.

35 The goals of medical nutrition therapy include maintaining blood glucose levels as near to
36 normal as possible, achieving optimal serum lipid levels, providing adequate calories, preventing
37 and treating the acute and long-term complications of diabetes, and improving overall health. To
38 accomplish these things, patients with diabetes need to understand how adjustments in food,
39 medication, and physical activity affect their glucose levels.

40 They also need to learn the importance of monitoring their weight, blood pressure, lipid
41 levels, blood glucose and glycosylated hemoglobin levels, and renal status. (2,4) The dietitian
42 works with each patient to revise the nutrition plan as needed, based on these outcomes.

43 **Meal plan centers around carb counting**

44 Current ADA nutrition guidelines include a system called the "consistent-carbohydrate
45 diabetes meal plan," which is replacing the traditional exchange system. (3) Instead of meal plans
46 with specific calorie requirements, this approach focuses on carbohydrate content. The patient eats
47 a comparable amount of carbohydrates at a given meal or snack each day, with the amount for
48 each prescribed individually.

49 Carbohydrate counting is the preferred approach to meal planning because it reflects a
50 more concrete and consistent connection between food, physical activity, and medication. Of all
51 the macro-nutrients, carbohydrates have the greatest effect on post-meal blood glucose levels.
52 Carbohydrates also determine pre-meal insulin requirements to a greater extent than does the
53 amount of protein or fat in the meal.

54 This doesn't mean that your patient should stop watching his intake of protein and fat. It's
55 necessary to watch both of these to avoid weight gain and serum lipid abnormalities, especially
56 since diabetes is a risk factor for cardiovascular disease. In general, a patient with diabetes should
57 get 10% -- 20% of his calories from animal or vegetable proteins--a recommendation similar to
58 that for the general population. Patients who have developed nephropathy may need to limit their
59 protein intake to about 10%.

60 The rest of the day's calories are distributed between fat and carbohydrates: 60% -- 70%
61 should come from carbohydrates and monosaturated fats, less than 10% from saturated fats, and
62 10% or less from polyunsaturated fats. (2) High-fiber foods can help keep blood sugar from rising
63 too fast after a meal, so remind patients to include them in their meal plans. A diabetes patient
64 typically needs 20-35 gm of fiber per day--the same as a person without diabetes.

65 Using these general guidelines and carbohydrate counting, the dietitian fine-tunes the
66 nutrition prescription and works with the nurse and other members of the healthcare team to help
67 the patient gradually learn how to manage his diet. (57) As the box on page 38 shows, the patient
68 progresses from learning how macro-nutrients affect blood glucose to advanced skills like
69 fine-tuning insulin doses based on carbohydrate intake at a given meal and level of physical

70 activity.

71 Here's how a typical scenario might unfold: Mr. Beecham has Type 2 diabetes and is being
72 treated with diet and exercise alone. At his initial nutrition assessment, he and the dietitian start
73 with a goal of 40 - 45 gm of carbohydrates at breakfast each day. To assess this, he's told to test
74 his blood sugar three times a day for one week: before breakfast, one hour after breakfast, and
75 before lunch. He's also instructed to document the type of food he eats, the serving size, its
76 carbohydrate content, and what activities (if any) he engages in each morning.

77 At Mr. Beecham's follow-up nutrition visit, he reviews the data with his dietitian. The
78 pattern reveals that his one-hour post-breakfast and his pre-lunch blood sugar levels are
79 consistently too high. Together, he and the dietitian look for reasons why and discuss strategies
80 to improve his glucose control.

81 For instance, he could add a morning walk to help lower his pre-lunch blood sugar levels.
82 Or he could decrease the carbohydrate amount at breakfast to 30-36 gm. Another strategy is to
83 spread out the morning carbohydrate allotment by eating a smaller breakfast but adding a
84 mid-morning snack. If these adjustments don't work, Mr. Beecham may need medication to help
85 control his glucose levels.

86 All of this takes practice, and it may not come easy to patients. They may turn to you,
87 their nurse, with their concerns and frustrations. You can help them along by reinforcing what has
88 been taught and by offering support and encouragement as they go through the process.

89 Seeing exercise as a therapeutic tool

90 Some patients with diabetes may have trouble understanding that, like diet, exercise is an
91 essential therapeutic tool. (8) In addition to its cardiovascular, weight, and overall health benefits,
92 regular exercise--especially the aerobic type--can increase insulin sensitivity. This, in turn, can
93 improve long-term glycemic control, reducing the need for insulin or oral medications. (9,10)

94 Remind patients to get a comprehensive physical exam before they begin exercising. The
95 exam should include assessments for cardiac and macro- and microvascular complications. Based
96 on this evaluation, the patient's exercise regimen should be individualized with an appropriate
97 level of both aerobic and anaerobic activities.

98 Aerobic exercise (repeated rhythmic movements of the large muscles) improves heart and
99 lung function, promotes endurance, and can lower blood glucose levels. Examples include brisk
100 walking, bicycling, swimming, cross-country skiing, tennis, dancing, and hiking. Anaerobic
101 exercise consists of short, rapid movements to build muscle mass or increase
102 strength--weightlifting, stretching, yoga, golf, sit-ups, and push-ups, for instance.

103 It's important that you tell patients who have not been exercising to start with aerobic
104 exercise only. Encourage them to choose an aerobic activity they enjoy and suggest that they
105 involve a friend or family member. This not only makes exercising more fun, but the social
106 support can help them comply with an exercise regimen.

107 You should caution patients that high-intensity, strenuous, or jarring activities, such as
108 high-resistance weightlifting, high-impact aerobics, and racquet sports, can raise blood pressure.
109 For that reason, those activities may not be appropriate for patients with retinopathy or kidney
110 problems because of the risk of further vascular damage. Also emphasize the importance of
111 wearing athletic shoes that fit well, are comfortable, and provide good support. Patients with
112 peripheral neuropathy may have to avoid exercise that causes trauma to the feet because they may

113 not feel soreness as blisters or cuts are developing.

114 Patients who haven't been physically active need to start slowly. Suggest, for example, that
115 they exercise for 10 minutes a day three to five times a week, and gradually progress to 30 - 45
116 minutes on most days. To prevent musculoskeletal injury, exercise should be preceded and
117 followed by five to 10 minutes of slow, continuous aerobic activity--walking or stationary cycling,
118 for example--and stretching, with each stretch held for 10-20 seconds.

119 How exercise may affect glucose levels

120 Because exercise uses up blood glucose and makes insulin work more efficiently,
121 hypoglycemia can occur during, or as late as 24 hours after, activity. Remind patients to always
122 check their blood glucose before they exercise, and to check it again during any exercise session
123 that lasts an hour or longer. If it's less than 100 mg/dL before exercising, the patient should
124 consume 15 gm of carbohydrates. He might, for example, have four to six crackers, 10 to 25
125 small pretzels, or one slice of bread.

126 Those with serum glucose levels greater than 240 mg/dL should check their urine or blood
127 for ketones and postpone exercise if they are present. (8,10) If a patient's blood glucose is greater
128 than 300 mg/dL and no ketosis is present, he should avoid exercise, since activity will lead to a
129 further increase in blood sugar.

130 All diabetes patients must be vigilant about their blood glucose during exercise as well.
131 Tell them to watch for symptoms of low blood sugar, such as dizziness, shakiness, headache,
132 faintness, nervousness, or blurred vision. If any of these develop, they should stop immediately
133 and re-check their blood sugar. They'll most likely need a carbohydrate snack. During prolonged
134 exercise some patients find that they need a carbohydrate snack every 30 minutes. Tell them to
135 always carry a source of fast-acting carbohydrates, such as glucose tablets or raisins.

136 Hyperglycemia is also a possibility during short-duration, high intensity activities—even if
137 patients have normal blood glucose levels beforehand. In patients with Type 1 diabetes, ketone
138 production may be stimulated and the patient may become nauseated or weak (which is why
139 testing beforehand is so important). If these symptoms occur, the patient should stop exercising,
140 take fluids, and follow any other recommendations from his healthcare provider.

141 Advise all patients with diabetes to test their blood sugar immediately after exercise . If
142 they have exercised for a long period , they should also check it again several hours later, since
143 they could develop delayed hypoglycemia. If blood sugar is below 100 mg/dL, the patient should
144 take four glucose tablets, or drink 4 ounces of juice or 6 ounces of regular soda, or eat a mini-box
145 of raisins.

146 Finally, warn patients that if they develop shortness of breath or pain in the chest,
147 shoulder, neck, or arm that lasts for more than a few seconds, they should stop their workout and
148 call their doctor or 911 at once.

149 As a nurse, you play a key role in coordinating the many facets of care for patients with
150 diabetes. Your encouragement and reinforcement of the steps they need to take to achieve that
151 unique balance of nutrition, medication, and physical activity will help ensure their success.

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174 health care professionals Alexandria, VA: Author.

175 A quick guide to nutrition and exercise

176 Nutrition and exercise are as much a part of your diabetes care as medication. Review this
177 handout periodically. Call your physician, certified diabetes educator, or registered dietitian (RD)
178 if you have any questions.

179 Nutrition

180 * Follow the meal plan developed by your RD.

181 * Keep a diary to help you identify how your diet, medications, and exercise/physical
182 activity affect your sugar levels.

183 * Eat a consistent amount of carbohydrates at every meal and snack. Eat about the same
184 time each day; don't skip any meals or snacks.

185 * Include high-fiber foods, which can help keep your blood sugar from rising too fast after
186 you eat. They include whole-grain cereals and breads, beans, peas, lentils and other legumes,
187 brown rice, barley, oats, and fresh fruits and vegetables.

188 * Reduce your fat intake, especially saturated fat. Cut back on butter, sour cream, fatty
189 meats, whole milk, cheese, fried foods, and chips.

190 * Avoid foods high in sodium if you have high blood pressure. Don't add salt to your
191 food.

192 * Use measuring cups and spoons and a food scale to estimate serving sizes more
193 accurately.

194 * Drink alcohol on a full stomach. Limit quantities as recommended by your healthcare
195 provider.

196 Exercise

197 * Check with your healthcare provider before starting an exercise program.

198 * Wear an emergency ID bracelet that says you have diabetes.

199 * Choose your footwear carefully to avoid blisters/sores.

200 * Limit exercise if the weather is extremely warm, humid, or cold. Don't exercise if
201 you're feeling ill or have an infection.

202 * Check your blood glucose level before and after exercise--and during high-intensity,
203 long-duration exercise. If it's too low, eat a complex carbohydrate snack (four to six crackers, 10
204 to 25 small pretzels, or one slice of bread). If it's too high, stop exercising. If you're on insulin,
205 take it as prescribed.

206 * Check your urine or blood for ketones if your blood sugar is higher than 240 mg/dL
207 before exercise. Postpone exercise if they're present. If no ketones are present but your blood
208 glucose is greater than 300 mg/dL, avoid exercise, since activity will lead to a further increase in
209 blood sugar.

210 * Don't exercise when insulin is peaking. This will help you to avoid hypoglycemia.

211 * Stop exercising and re-check your blood sugar if you feel weak, shaky, dizzy, sick to
212 your stomach, or irritable, or if you develop a headache.

213 * Always carry a source of fast-acting carbohydrates, such as glucose tablets, raisins, or
214 juice, in case your blood sugar falls too low.

215 * Stop exercising and call for help immediately if you develop pain or tightness in the chest
216 or chest/upper arm, heart palpitations, or shortness of breath.

217 **Travel tips**

218 * Choose foods that are grilled, baked, steamed, or boiled--not fried. Ask for sauces and
219 dressings "on the side."

220 * Always carry a snack in case your mealtime plans change or travel is delayed. Plan
221 ahead: Find out whether a meal or snack will be served on your flight.

222 * Continue to monitor your blood sugar when you travel, especially after you've eaten
223 food you don't usually eat.

224 * Take enough medication, insulin, and supplies for your trip--plus a little extra.

225 * Always schedule physical activity into your day. Take stretch breaks. If no gym is
226 available, walk.

227 **Carbohydrate counting: The basis for nutritional self-management**

228 For patients with diabetes, carbohydrate counting has emerged as a preferred
229 meal-planning approach for achieving optimal blood glucose control. The method involves three
230 levels of knowledge and skill, each increasing in complexity but promoting greater flexibility in
231 food choices.

232 **Level 1: Basic Patients learn:**

233 * how macronutrients affect blood glucose and overall health.

234 * which foods contain carbohydrates (e.g., bread, crackers, fruit milk, cake, and
235 vegetables).

236 * which size of food portions equals one carbohydrate choice (15 g).

237 * the importance of consuming consistent amounts of carbohydrates at meals and snacks.

238 * how to use food scales, measuring cups, and spoons to size portions.

239 * how to read nutrition labels.

240 * how to develop a beginning meal plan.

241 * how to keep food records that include pre- and post-meal blood glucose, carbohydrate

242 intake, and physical activity.

243 Level 2: Intermediate Patients learn:

244 * the relationship between food, medication, and physical activity.

245 * how to recognize and interpret blood glucose patterns.

246 * the strategies for managing blood glucose variations. These strategies include changing
247 insulin doses, amount of carbohydrates, timing of carbohydrates intake, and amount of physical
248 activity.

249 * how to use reference charts to determine the carbohydrate content of foods. They should
250 also know how to translate complex foods such as restaurant meals, take-out foods, or
251 combination foods into grams of carbohydrates.

252 * how excess protein and fat can contribute to weight gain, lipid abnormalities, and higher
253 post-meal glucose levels three to five hours after a meal.

254 * how to make modest adjustments in insulin doses based on carbohydrate intake.

255 Level 3: Advanced Patients learn:

256 * how to further implement knowledge and skills of previous levels.

257 * how to use carbohydrate-to-insulin ratios based on pre- and post-meal blood glucose
258 results, insulin doses, carbohydrate intake, and physical activity records.

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NUTRITION AND EXERCISE.

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1 TEXT: Nutrition and exercise aren't merely adjuncts to treating diabetes, they're essential
2 components of the prescription for effective care. Understanding what they entail will help you
3 support your patients and work effectively with other members of the diabetes team.

4 Nutrition and exercise are essential to maintaining the health and quality of life of people
5 with diabetes mellitus. In light of this fact, patients with diabetes have a lot to learn: how to
6 monitor their blood glucose levels, what changes to make in their eating habits, and how to sustain
7 prescribed levels of physical activity. In addition, many will have to learn how to comply with
8 a regimen of oral antidiabetic agents, insulin, or both.

9 Acquiring these skills can be a monumental task, one that patients should not be expected
10 to accomplish alone. That's why managing diabetes requires ongoing intervention and education
11 by a concerned multidisciplinary team, which should include--at a minimum--the patient's
12 physician, a nurse, and a registered dietitian (RD). Because a nurse and a dietitian do much of the
13 patient teaching, they should have specialized training or certification in diabetes and education.
14 (1)

15 Whether you're an official member of the diabetes team or you

16 JOCELYN GOLDBERG is an advanced practice nutritionist at the Mount Sinai Diabetes
17 Center in New York City.

18 STAFF EDITOR. Emil Vernarec simply have patients with diabetes in your care, you need
19 to understand how nutrition and exercise affect blood glucose. With this knowledge, you will be
20 better able to support your patient's adherence to the nutrition, exercise, and self-management
21 plans developed by the team.

22 Diet is best seen as a "nutrition prescription"

23 For patients with either Type 1 or Type 2 diabetes, diet should be considered medical
24 nutrition therapy. According to the American Diabetes Association (ADA), there is no one
25 "diabetic" or "ADA" diet; instead, what's required is an individualized "nutrition prescription."

26 Individualizing medical nutrition therapy can be a complex task. That's why the ADA

27 recommends that it be done by an RD, who takes into account the patient assessment, outcomes,
28 and treatment goals. (2,3) The assessment is a detailed one. It needs to include the patient's
29 medical history, current medication use, frequency and results of blood glucose monitoring, lab
30 data, height and weight history, body composition results, typical eating patterns, timing of meals
31 and snacks, and exercise regimen.

32 It also must include patient lifestyle data, such as work schedule and frequency of dining
33 out or eating take-out food. The patient's learning style, readiness to change, and any barriers to
34 such change must also be taken into account.

35 The goals of medical nutrition therapy include maintaining blood glucose levels as near to
36 normal as possible, achieving optimal serum lipid levels, providing adequate calories, preventing
37 and treating the acute and long-term complications of diabetes, and improving overall health. To
38 accomplish these things, patients with diabetes need to understand how adjustments in food,
39 medication, and physical activity affect their glucose levels.

40 They also need to learn the importance of monitoring their weight, blood pressure, lipid
41 levels, blood glucose and glycosylated hemoglobin levels, and renal status. (2,4) The dietitian
42 works with each patient to revise the nutrition plan as needed, based on these outcomes.

43 Meal plan centers around carb counting

44 Current ADA nutrition guidelines include a system called the "consistent-carbohydrate
45 diabetes meal plan," which is replacing the traditional exchange system. (3) Instead of meal plans
46 with specific calorie requirements, this approach focuses on carbohydrate content. The patient eats
47 a comparable amount of carbohydrates at a given meal or snack each day, with the amount for
48 each prescribed individually.

49 Carbohydrate counting is the preferred approach to meal planning because it reflects a
50 more concrete and consistent connection between food, physical activity, and medication. Of all
51 the macro-nutrients, carbohydrates have the greatest effect on post-meal blood glucose levels.
52 Carbohydrates also determine pre-meal insulin requirements to a greater extent than does the
53 amount of protein or fat in the meal.

54 This doesn't mean that your patient should stop watching his intake of protein and fat. It's
55 necessary to watch both of these to avoid weight gain and serum lipid abnormalities, especially
56 since diabetes is a risk factor for cardiovascular disease. In general, a patient with diabetes should
57 get 10% -- 20% of his calories from animal or vegetable proteins--a recommendation similar to
58 that for the general population. Patients who have developed nephropathy may need to limit their
59 protein intake to about 10%.

60 The rest of the day's calories are distributed between fat and carbohydrates: 60% -- 70%
61 should come from carbohydrates and monosaturated fats, less than 10% from saturated fats, and
62 10% or less from polyunsaturated fats. (2) High-fiber foods can help keep blood sugar from rising
63 too fast after a meal, so remind patients to include them in their meal plans. A diabetes patient
64 typically needs 20-35 gm of fiber per day--the same as a person without diabetes.

65 Using these general guidelines and carbohydrate counting, the dietitian fine-tunes the
66 nutrition prescription and works with the nurse and other members of the healthcare team to help
67 the patient gradually learn how to manage his diet. (57) As the box on page 38 shows, the patient
68 progresses from learning how macro-nutrients affect blood glucose to advanced skills like
69 fine-tuning insulin doses based on carbohydrate intake at a given meal and level of physical

70 activity.

71 Here's how a typical scenario might unfold: Mr. Beecham has Type 2 diabetes and is being
72 treated with diet and exercise alone. At his initial nutrition assessment, he and the dietitian start
73 with a goal of 40 - 45 gm of carbohydrates at breakfast each day. To assess this, he's told to test
74 his blood sugar three times a day for one week: before breakfast, one hour after breakfast, and
75 before lunch. He's also instructed to document the type of food he eats, the serving size, its
76 carbohydrate content, and what activities (if any) he engages in each morning.

77 At Mr. Beecham's follow-up nutrition visit, he reviews the data with his dietitian. The
78 pattern reveals that his one-hour post-breakfast and his pre-lunch blood sugar levels are
79 consistently too high. Together, he and the dietitian look for reasons why and discuss strategies
80 to improve his glucose control.

81 For instance, he could add a morning walk to help lower his pre-lunch blood sugar levels.
82 Or he could decrease the carbohydrate amount at breakfast to 30-36 gm. Another strategy is to
83 spread out the morning carbohydrate allotment by eating a smaller breakfast but adding a
84 mid-morning snack. If these adjustments don't work, Mr. Beecham may need medication to help
85 control his glucose levels.

86 All of this takes practice, and it may not come easy to patients. They may turn to you,
87 their nurse, with their concerns and frustrations. You can help them along by reinforcing what has
88 been taught and by offering support and encouragement as they go through the process.

89 Seeing exercise as a therapeutic tool

90 Some patients with diabetes may have trouble understanding that, like diet, exercise is an
91 essential therapeutic tool. (8) In addition to its cardiovascular, weight, and overall health benefits,
92 regular exercise--especially the aerobic type--can increase insulin sensitivity. This, in turn, can
93 improve long-term glycemic control, reducing the need for insulin or oral medications. (9,10)

94 Remind patients to get a comprehensive physical exam before they begin exercising. The
95 exam should include assessments for cardiac and macro- and microvascular complications. Based
96 on this evaluation, the patient's exercise regimen should be individualized with an appropriate
97 level of both aerobic and anaerobic activities.

98 Aerobic exercise (repeated rhythmic movements of the large muscles) improves heart and
99 lung function, promotes endurance, and can lower blood glucose levels. Examples include brisk
100 walking, bicycling, swimming, cross-country skiing, tennis, dancing, and hiking. Anaerobic
101 exercise consists of short, rapid movements to build muscle mass or increase
102 strength--weightlifting, stretching, yoga, golf, sit-ups, and push-ups, for instance.

103 It's important that you tell patients who have not been exercising to start with aerobic
104 exercise only. Encourage them to choose an aerobic activity they enjoy and suggest that they
105 involve a friend or family member. This not only makes exercising more fun, but the social
106 support can help them comply with an exercise regimen.

107 You should caution patients that high-intensity, strenuous, or jarring activities, such as
108 high-resistance weightlifting, high-impact aerobics, and racquet sports, can raise blood pressure.
109 For that reason, those activities may not be appropriate for patients with retinopathy or kidney
110 problems because of the risk of further vascular damage. Also emphasize the importance of
111 wearing athletic shoes that fit well, are comfortable, and provide good support. Patients with
112 peripheral neuropathy may have to avoid exercise that causes trauma to the feet because they may

113 not feel soreness as blisters or cuts are developing.

114 Patients who haven't been physically active need to start slowly. Suggest, for example, that
115 they exercise for 10 minutes a day three to five times a week, and gradually progress to 30 - 45
116 minutes on most days. To prevent musculoskeletal injury, exercise should be preceded and
117 followed by five to 10 minutes of slow, continuous aerobic activity--walking or stationary cycling,
118 for example--and stretching, with each stretch held for 10-20 seconds.

119 How exercise may affect glucose levels

120 Because exercise uses up blood glucose and makes insulin work more efficiently,
121 hypoglycemia can occur during, or as late as 24 hours after, activity. Remind patients to always
122 check their blood glucose before they exercise, and to check it again during any exercise session
123 that lasts an hour or longer. If it's less than 100 mg/dL before exercising, the patient should
124 consume 15 gm of carbohydrates. He might, for example, have four to six crackers, 10 to 25
125 small pretzels, or one slice of bread.

126 Those with serum glucose levels greater than 240 mg/dL should check their urine or blood
127 for ketones and postpone exercise if they are present. (8,10) If a patient's blood glucose is greater
128 than 300 mg/dL and no ketosis is present, he should avoid exercise, since activity will lead to a
129 further increase in blood sugar.

130 All diabetes patients must be vigilant about their blood glucose during exercise as well.
131 Tell them to watch for symptoms of low blood sugar, such as dizziness, shakiness, headache,
132 faintness, nervousness, or blurred vision. If any of these develop, they should stop immediately
133 and re-check their blood sugar. They'll most likely need a carbohydrate snack. During prolonged
134 exercise some patients find that they need a carbohydrate snack every 30 minutes. Tell them to
135 always carry a source of fast-acting carbohydrates, such as glucose tablets or raisins.

136 Hyperglycemia is also a possibility during short-duration, high intensity activities--even if
137 patients have normal blood glucose levels beforehand. In patients with Type 1 diabetes, ketone
138 production may be stimulated and the patient may become nauseated or weak (which is why
139 testing beforehand is so important). If these symptoms occur, the patient should stop exercising,
140 take fluids, and follow any other recommendations from his healthcare provider.

141 Advise all patients with diabetes to test their blood sugar immediately after exercise . If
142 they have exercised for a long period , they should also check it again several hours later, since
143 they could develop delayed hypoglycemia. If blood sugar is below 100 mg/dL, the patient should
144 take four glucose tablets, or drink 4 ounces of juice or 6 ounces of regular soda, or eat a mini-box
145 of raisins.

146 Finally, warn patients that if they develop shortness of breath or pain in the chest,
147 shoulder, neck, or arm that lasts for more than a few seconds, they should stop their workout and
148 call their doctor or 911 at once.

149 As a nurse, you play a key role in coordinating the many facets of care for patients with
150 diabetes. Your encouragement and reinforcement of the steps they need to take to achieve that
151 unique balance of nutrition, medication, and physical activity will help ensure their success.

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175 A quick guide to nutrition and exercise

176 Nutrition and exercise are as much a part of your diabetes care as medication. Review this
177 handout periodically. Call your physician, certified diabetes educator, or registered dietitian (RD)
178 if you have any questions.

179 Nutrition

180 * Follow the meal plan developed by your RD.

181 * Keep a diary to help you identify how your diet, medications, and exercise/physical
182 activity affect your sugar levels.

183 * Eat a consistent amount of carbohydrates at every meal and snack. Eat about the same
184 time each day; don't skip any meals or snacks.

185 * Include high-fiber foods, which can help keep your blood sugar from rising too fast after
186 you eat. They include whole-grain cereals and breads, beans, peas, lentils and other legumes,
187 brown rice, barley, oats, and fresh fruits and vegetables.

188 * Reduce your fat intake, especially saturated fat. Cut back on butter, sour cream, fatty
189 meats, whole milk, cheese, fried foods, and chips.

190 * Avoid foods high in sodium if you have high blood pressure. Don't add salt to your
191 food.

192 * Use measuring cups and spoons and a food scale to estimate serving sizes more
193 accurately.

194 * Drink alcohol on a full stomach. Limit quantities as recommended by your healthcare
195 provider.

196 Exercise

197 * Check with your healthcare provider before starting an exercise program.

198 * Wear an emergency ID bracelet that says you have diabetes.

- * Choose your footwear carefully to avoid blisters/sores.
- * Limit exercise if the weather is extremely warm, humid, or cold. Don't exercise if you're feeling ill or have an infection.
 - * Check your blood glucose level before and after exercise--and during high-intensity, long-duration exercise. If it's too low, eat a complex carbohydrate snack (four to six crackers, 10 to 25 small pretzels, or one slice of bread). If it's too high, stop exercising. If you're on insulin, take it as prescribed.
 - * Check your urine or blood for ketones if your blood sugar is higher than 240 mg/dL before exercise. Postpone exercise if they're present. If no ketones are present but your blood glucose is greater than 300 mg/dL, avoid exercise, since activity will lead to a further increase in blood sugar.
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 - * Stop exercising and call for help immediately if you develop pain or tightness in the chest or chest/upper arm, heart palpitations, or shortness of breath.
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 - * Always carry a snack in case your mealtime plans change or travel is delayed. Plan ahead: Find out whether a meal or snack will be served on your flight.
 - * Continue to monitor your blood sugar when you travel, especially after you've eaten food you don't usually eat.
 - * Take enough medication, insulin, and supplies for your trip--plus a little extra.
 - * Always schedule physical activity into your day. Take stretch breaks. If no gym is available, walk.
- Carbohydrate counting: The basis for nutritional self-management

For patients with diabetes, carbohydrate counting has emerged as a preferred meal-planning approach for achieving optimal blood glucose control. The method involves three levels of knowledge and skill, each increasing in complexity but promoting greater flexibility in food choices.

Level 1: Basic Patients learn:

 - * how macronutrients affect blood glucose and overall health.
 - * which foods contain carbohydrates (e.g., bread, crackers, fruit milk, cake, and vegetables).
 - * which size of food portions equals one carbohydrate choice (15 g).
 - * the importance of consuming consistent amounts of carbohydrates at meals and snacks.

* how to use food scales, measuring cups, and spoons to size portions.

 - * how to read nutrition labels.
 - * how to develop a beginning meal plan.
 - * how to keep food records that include pre- and post-meal blood glucose, carbohydrate

242 intake, and physical activity.

243 Level 2: Intermediate Patients learn:

244 * the relationship between food, medication, and physical activity.

245 * how to recognize and interpret blood glucose patterns.

246 * the strategies for managing blood glucose variations. These strategies include changing
247 insulin doses, amount of carbohydrates, timing of carbohydrates intake, and amount of physical
248 activity.

249 * how to use reference charts to determine the carbohydrate content of foods. They should
250 also know how to translate complex foods such as restaurant meals, take-out foods, or
251 combination foods into grams of carbohydrates.

252 * how excess protein and fat can contribute to weight gain, lipid abnormalities, and higher
253 post-meal glucose levels three to five hours after a meal.

254 * how to make modest adjustments in insulin doses based on carbohydrate intake.

255 Level 3: Advanced Patients learn:

256 * how to further implement knowledge and skills of previous levels.

257 * how to use carbohydrate-to-insulin ratios based on pre- and post-meal blood glucose
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